CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1103	**Date: NOVEMBER 3, 2006**
	Change Request 5263

SUBJECT: Reporting and Payment of No-Cost Devices Furnished by Outpatient Prospective Payment System (OPPS) Hospitals

I. SUMMARY OF CHANGES: Providers shall report modifier -FB when they report replacement of an implanted device with a device for which they incurred no cost or when they are replacing an implanted device with a device for which they received a credit in the amount of the cost of the replaced device. Payment for replacement procedure is reduced by the offset amount applicable to the ambulatory payment classification (APC) group for the year in which the service was furnished. These offset amounts are displayed on the OPPS CMS Web site at: http://www.cms.hhs.gov/HospitalOutpatientPPS/.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	4/Table of Contents
N	4/20.6.9/Use of HCPCS Modifier-FB
N	4/61.3/Billing for Devices Replaced Without Cost to an OPPS Hospital or Beneficiary or for Which the Hospital Receives a Credit and Payment for OPPS Services Required to Replace the Device
N	4/61.3.1/Reporting and Charge Requirements When a Device is Replaced Without Cost to the Hospital
N	4/61.3.2/Reporting and Charge Requirements When the Hospital Receives Credit for the Replaced Device against the Cost of a More Expensive Replacement Device

N	4/61.3.3/Medicare Payment Adjustment

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment –Business Requirements

Pub. 100-04	Transmittal: 1103	Date: November 3, 2006	Change Request 5263

SUBJECT: Reporting and Payment of No-Cost and Reduced Cost Devices Furnished by Outpatient Prospective Payment System (OPPS) Hospitals

I. GENERAL INFORMATION

A. Background: This instruction specifies how no-cost and reduced cost devices are to be reported and paid for hospitals paid under the Outpatient Prospective Payment System (OPPS). In general, Medicare packages payment for devices into the payment for the service in which the device is used. In some cases, the cost of the device is a very large proportion of the cost for the procedure on which the APC payment for the procedure is based. Therefore, it is necessary to adjust the payment for the APC so that it no longer includes payment for a device that is being furnished without cost to the beneficiary.

Medicare requires that hospitals paid under OPPS must report the HCPCS code for devices that they use in performing a service, including those implanted in the patient, temporarily or permanently. The Outpatient Code Editor (OCE) will return to the provider claims for selected HCPCS procedures if an approved HCPCS code for the device is not on the claim. The Fiscal Intermediary Standard System (FISS) requires that there be a charge for each HCPCS code reported on the claim. Therefore, it is not possible for an OPPS hospital to refrain from billing for a device furnished under warranty, without cost to the provider or beneficiary.

In Transmittal 599, Change Request (CR) 3915 issued June 30, 2005, CMS authorized hospitals to report a token charge of less than $1.01 for the device, in these cases, so that the claim could be processed. In Transmittal 804, CR 4250 issued January 3, 2006, CMS announced the creation of modifier -FB, ***Item Provided Without Cost to Provider, Supplier or Practitioner (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)***. However, effective January 1, 2007, CMS will expand the definition of modifier -FB to include credits received for a replacement device by a hospital from a manufacturer or other entity.

B. Policy: Providers shall report modifier -FB when they report replacement of an implanted device with a device for which they incurred no cost or when they are replacing an implanted device with a device for which they received a credit in the amount of the cost of the replaced device. Payment for the replacement procedure is reduced by the offset amount applicable to the APC for the year in which the service was furnished. These offset amounts are displayed on the OPPS CMS Web site at: http://www.cms.hhs.gov/HospitalOutpatientPPS/.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5263.1	The OPPS Outpatient Code Editor (OCE) shall assign a Payment Adjustment Flag #7 (Item provided without cost to provider) to lines that meet the following: • Have a Healthcare Common Procedure Coding System (HCPCS) code -FB modifier, and • Are assigned to APCs to which the reduction applies									OPPS OCE
5263.1.1	The OPPS OCE shall use the offset APC payment rate (APC payment amount minus the established offset) as the rate used in the OCE's determination of which multiple procedure line(s) will be discounted.									OPPS OCE
5263.2	The OPPS PRICER shall reduce the unadjusted (pre-wage adjusted) APC payment by the amount of reductions specified for the applicable APC when an OPPS line is processed with a Payment Adjustment Flag #7.									OPPS PRICER
5263.2.1	The OPPS PRICER shall calculate coinsurance based on the reduced payment amount.									OPPS PRICER
5263.3	OCE shall create line item edit # 75 that returns to the provider claims when modifier –FB is appended to a code with status indicator other than: S, T, V, or X.									OPPS OCE
5263.3.1	FI shall return to provider claims when modifier –FB is appended to a code with status indicator other than: S, T, V, or X.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5263.4	OCE shall apply the 50% terminated procedure discount to the offset APC amount on OPPS lines that contain an -FB modifier along with a terminated procedure modifier -52 or -73.									OPPS OCE

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5263.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X								
5263.6	FIs shall educate hospitals paid under OPPS to report HCPCS modifier -FB with the HCPCS code for a procedure that requires a device for which neither the hospital, nor the beneficiary, has an obligation to pay.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5263.6.1	FIs shall educate hospitals to report the FB modifier when the hospital is given credit towards a replacement device in the amount of the cost of the device being replaced.	X								
5263. 7	FIs shall educate hospitals paid under OPPS to charge less than $1.01 for the applicable device when they replace a device furnished without cost by the manufacturer.	X								
5263.8	FIs shall educate hospitals paid under OPPS to charge the difference between the hospital's usual charge for the replacement device, and the usual charge for the device being replaced when they receive credit for the device being replaced but implant a more costly device.	X								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N\A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2007 **Implementation Date:** January 2, 2007 **Pre-Implementation Contact(s):** Anita Heygster 410-786-4486 Post-Implementation Contact(s): Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Attachment – Claim Examples

Attachment

Example	HCPCS	Description	SI	Units	Charge	APC	Unadjusted Payment	Offset Amount	New Unadj. Payment
Claim 1: Free ICD Device	G0297 **FB**	Implant ICD	T	1	$6000	107	$16,000	$14,000	$2,000
	C1772	ICD	N	1	$1	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
Claim 2: Credit for Device Upgrade	G0297 **FB**	Implant ICD	T	1	$6000	107	$16,000	$14,000	$2,000
	C1772	ICD	N	1	$5000	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
Claim 3: Multiple Procedure Discount	G0297 **FB**	Implant ICD	T	1	$6000	107	$16,000	$14,000	$1,000 ($2,000 x .5)
	C1772	ICD	N	1	$1	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
	33241	Removal Pulse Generator	T	1	$5,000	105	$2,500	---	$2,500
Claim 4: Terminated Procedure along with free device	G0297 **FB and 73**	Implant ICD	T	1	$6000	107	$16,000	$14,000	$1,000 ($2,000 x .5)
	C1772	ICD	N	1	$1	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
Claim 5: FB Modifier on Free Device Line	G0297	Implant ICD	T	1	$6000	107	OCE Edit #75: Incorrect billing of FB modifier		
	C1772 **FB**	ICD	N	1	$1	---			
	93005	EKG	S	2	$100	99			

Disclaimer: The above claim examples are hypothetical only and aim to reflect the pricing concepts, effective January 1, 2007. The rates above do not represent actual payment rates as they are rounded to simplify the claims scenario.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev.1103, 11-03-06)

20.6.9 - Use of HCPCS Modifier -FB

(Rev.1103, Issued: 11-03-06, Effective: 01-01-07, Implementation: 01-02-07)

*Effective January 1, 2007, the definition of modifier -FB is "**Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)**". See the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §61.3 for instructions regarding charges for items billed with the -FB modifier.*
The OPPS hospitals must report modifier -FB on the same line as the procedure code (not the device code) for a service that requires a device for which neither the hospital, nor the beneficiary, is liable to the manufacturer. Hospitals must report modifier -FB on the same line as the procedure code for a service that requires a device when the manufacturer gives credit for a device being replaced with a more costly device.

61.3 - Billing for Devices Replaced Without Cost to an OPPS Hospital or Beneficiary or for Which the Hospital Receives a Credit and Payment for OPPS Services Required to Replace the Device

(Rev.1103, Issued: 11-03-06, Effective: 01-01-07, Implementation: 01-02-07)

61.3.1 - Reporting and Charge Requirements When a Device is Replaced Without Cost to the Hospital

(Rev.1103, Issued: 11-03-06, Effective: 01-01-07, Implementation: 01-02-07)

When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS Web site at: www.cms.hhs.gov/HospitalOutpatientPPS); and 2) receives the device without cost from a manufacturer, the hospital must append modifier -FB to the procedure code (not the device code) that reports the services provided to replace the device. The hospital must report a token charge for the device (less than $1.01) in the covered charges field.

61.3.2 - Reporting and Charge Requirements When the Hospital Receives Credit for the Replaced Device against the Cost of a More Expensive Replacement Device

(Rev.1103, Issued: 11-03-06, Effective: 01-01-07, Implementation: 01-02-07)

When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS Web site at: www.cms.hhs.gov/HospitalOutpatientPPS); and 2) receives a credit in the amount that the device being replaced would otherwise cost, the hospital must append modifier -FB to the procedure code(not on the device code) that reports the services provided to replace the device. The hospital must charge the difference between its usual charge for the device being implanted and its usual charge for the device for which it received credit. This charge should be billed in the covered charges field.

61.3.3 - Medicare Payment Adjustment

(Rev.1103, Issued: 11-03-06, Effective: 01-01-07, Implementation: 01-02-07)

Effective January 1, 2007, Medicare payment is reduced by an offset amount for specified device procedure codes reported with an -FB modifier. Only procedure codes that map to the Ambulatory Payment Classification groups (APCs) on the list of APCs subject to the adjustment, and are reported with an -FB modifier, will be reduced by the offset amount.

The OPPS OCE assigns a payment adjustment flag when a code in an APC subject to an offset adjustment is billed with modifier-FB. The payment adjustment flag communicates to the OPPS PRICER that the payment for the procedure code line is to be reduced by the established offset amount for the APC to which the procedure code is assigned.

The OPPS PRICER applies the multiple procedure discounting factor prior to offsetting the unadjusted APC. The offset reduction is made to the unadjusted payment rate before wage adjustment, which ensures that the beneficiary's coinsurance is based on the reduced amount.

***NOTE**: For procedure codes assigned to the device adjusted APCs, and for the amount of the reduction, see the table of APCs and devices to which the offset applies on the CMS Web site at: www.cms.hhs.gov/HospitalOutpatientPPS/.*